Data-Driven Performance Payment System (DPPS):
Solving the Problems with the Merit-based Incentive Payment System (MIPS)

MIPS Background

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2025 consolidated three historic quality reporting programs into MIPS. MIPS requires physicians to report on quality measures, health IT measures, and improvement activities, creating significant administrative burden. The Centers for Medicare & Medicaid Services (CMS) also calculates cost measures and a new population health category (not-statutorily required) using claims data. CMS combines all of this data and generates a score of 0-100 points. Based on how their score compares to the national benchmark, physicians will see a penalty, a neutral payment adjustment, or a bonus. MIPS adjusts Medicare physician payment for all physicians unless they're new to Medicare, qualifying alternative payment model participants, or have a low volume of Medicare patients or payments. The program is budget neutral. Penalties of up to -9 percent fund the bonuses.

Why are reforms to MIPS necessary?

- **MIPS disproportionately penalizes small and rural practices.** More than 45 percent of solo eligible clinicians (ECs), 31 percent of small practices, and 18 percent of rural practices received a MIPS penalty in 2024 compared to fewer than 14 percent of ECs overall. Nearly 30 percent of solo ECs and 12 percent of small practices received the maximum -9 percent penalty compared to 2 percent of ECs overall.
- **MIPS is burdensome and costly.** MIPS compliance costs $12,800 and requires 202 hours per physician per year according to a 2021 Journal of the American Medical Association (JAMA) Health Forum study.
- **MIPS does not measure quality and exacerbates health inequities.** According to a 2022 JAMA study, MIPS scores are approximately as effective as chance in terms of identifying high versus low quality performance. Researchers found physicians providing high quality care but with low MIPS scores tended to have practices catering to a greater number of sicker and lower-income patients.
- **There are too few clinically relevant measures for specialists.** MIPS scoring rules also disincentivize reporting on certain quality measures that are tailored to specialty care.

Introducing DPPS

It has been almost 10 years since MACRA passed, and change is urgently needed to reduce the harmful effects of MIPS. Designed as an alternative to MIPS, DPPS has been endorsed by the AMA, every state medical society, and more than 100 national specialty societies. DPPS would reset Medicare's approach to improving quality and reducing avoidable costs by decreasing undue administrative burden; supporting small, rural and safety net practices; and increasing the clinical relevance of quality and cost measures to physicians and patients.

How does DPPS support small, rural, and safety net practices by reducing steep penalties?

- DPPS would eliminate the win-lose tournament model and reduce the maximum penalty from -9 percent to one-half of a physician's annual payment update (for example, 0.25 percent under current law or the increase in the Medicare Economic Index if H.R. 2474 passes), which is similar to other Medicare programs such as the Hospital Inpatient Quality Reporting Program.
- It would reinvest penalties in quality improvement and alternative payment model readiness by assisting under-resourced practices with their value-based care transformation.
- DPPS would freeze the performance threshold at 60 points for at least three years to reduce steep penalties as practices continue to recover from the effects of the COVID-19 pandemic and Change Healthcare data breach.

How does DPPS decrease the burden of MIPS?

- By removing siloes between the four performance categories, DPPS would streamline reporting requirements.
- Physicians could meet the health IT requirements via “yes/no” attestation of using certified electronic health record technology, participation in a clinical data registry, or other less burdensome means. Participation in a qualifying registry would automatically count toward fulfilling improvement activities.
- DPPS would align with other Medicare value-based programs, giving physicians an opportunity to be measured on the care they provide in hospitals and other settings without having to report duplicative data.

How does DPPS improve the clinical relevance and accuracy of cost and quality measures for physicians and patients?

- DPPS would incentivize CMS to fulfill its statutory obligations to share data on a quarterly basis, enabling physicians to improve performance on quality and cost measures.
- By replacing broad, problematic cost measures with more targeted episode-based cost measures, DPPS would better target cost variability that a physician can influence.
- Physicians would receive pay-for-reporting credit for three years if they report new or significantly revised quality measures, increasing the incentive to report on new quality measures and improving the accuracy of the data.